AN ACT relating to Federal Requirements for Health Insurance.

Be it enacted by the General Assembly of the Commonwealth of Kentucky:

SECTION 1. A NEW SECTION OF SUBTITLE 12 OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

For the purpose of Section 2 through Section 4 of this act:

(1) "Excepted coverage" means insurance that provides coverage for:

(a) Accident, or disability income insurance, or any combination thereof;

(b) A supplement to liability insurance;

(c) Liability insurance, including general liability insurance and automobile liability insurance;

(d) Workers' compensation or similar insurance;

(e) Automobile medical payment insurance;

(f) Credit-only insurance;

(g) Coverage for on-site medical clinics;

(h) If offered separately:

1. Limited scope dental or vision benefits; or

2. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or

(i) If offered as independent, noncoordinated benefits:

1. Specified disease or illness; or

2. Hospital indemnity or other fixed indemnity insurance.

(2) "Family member" means, with respect to any individual:

(a) A dependent of such individual; and

(b) Any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual or of an individual described in paragraph (a) of this subsection.

(3) (a) "Genetic information" means, with respect to any individual, information about:

1. The individual's genetic tests;

2. The genetic tests of family members of the individual; and

3. The manifestation of a disease or disorder in family members of the individual;

(b) Genetic information includes:

1. Any request for, or receipt of, genetic services; or

2. Participation in clinical research which includes genetic services, by an individual or any family member of an individual; and

(c) Genetic information shall not include information about the sex or age of any individual.

(4) (a) "Genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detects genotypes, mutations, or chromosomal changes.

(b) Genetic test shall not include:

1. An analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes;

2. An analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in

the field of medicine involved.

(5) "Genetic services" means:

(a) A genetic test;

(b) Genetic counseling including obtaining, interpreting, or assessing genetic information; or

(c) Genetic education.

(6) "Underwriting purposes" means, with respect to any group health plan or health insurance coverage offered in connection with a group health plan:

(a) Rules for, or determination of, eligibility, including enrollment and continued eligibility, for benefits under the plan or coverage;

(b) The computation of premium or contribution amounts under the plan or coverage;

(c) The application of any pre-existing condition exclusion under the plan or coverage; and

(d) Other activities related to the creation, renewal, or replacement of a contract of health insurance.

SECTION 2. A NEW SECTION OF SUBTITLE 12 OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) An insurer offering health insurance that is not an excepted coverage shall not adjust premium or contribution amounts for the group or individual covered under the health insurance on the basis of genetic information.

(2) This section shall not be construed to limit the ability of an insurer offering health insurance to:

(a) A group to increase the premium for a group based on the manifestation of a disease or disorder of an individual who is enrolled in the plan. In such case, the manifestation of a disease or disorder in one individual shall not be used as genetic information about other group members and to further increase the premium for the group.

(b) An individual from adjusting premium or contribution amounts on the basis of a manifestation of a disease or disorder in that individual, or in a family member of the individual if the family member is covered under the same policy that covers the individual. In that case, the manifestation of a disease or disorder in one individual shall not be used as genetic information about other individuals covered under the policy issued to the individual and to further increase premiums or contribution amounts.

(3) (a) A health insurer offering health insurance in the group or individual market shall not request or require an individual or a family member of the individual to undergo a genetic test.

(b) This subsection shall not:

1. Limit the authority of a health care professional who is providing health care services to an individual to request that the individual undergo a genetic test.

2. Be construed to preclude a health insurer from obtaining and using the results of a genetic test in making a determination regarding payment, as defined by the Health Insurance Portability and Accountability Act of 1996, consistent with paragraph (a) of this subsection.

(c) For purposes of paragraph (a) of this subsection, an insurer may request only the minimum amount of information necessary to accomplish the intended purpose.

(4) Notwithstanding subsection (2) of this section, an insurer may request, but not require, that a participant or beneficiary undergo a genetic test if each of the following conditions is met:

(a) The request is made pursuant to research that complies with part 46 of title 45, Code of Federal Regulations, or equivalent Federal regulations, and any applicable administrative regulations for the protection of human subjects in research.

(b) The insurer clearly indicates to each individual, or in the case of a minor child, to the legal guardian of the beneficiary, to whom the request is made that:

1. Compliance with the request is voluntary; and

2. Non-compliance will have no effect on enrollment status or premium or contribution amounts.

(c) Genetic information collected or acquired under this subsection shall not be used for underwriting purposes.

(d) The insurer notifies the executive director and U.S. Secretary of the Department for Health and Human Services, and if applicable, the U.S. Secretary of the Department of Labor, in writing, that the insurer is conducting activities pursuant to the exception provided for under this subsection, including a description of the activities conducted.

(e) The insurer complies with other conditions as the executive director, U.S. Secretary of the Department for Health and Human Services or U.S. Secretary of the Department of Labor may, by administrative regulation, require for activities

conducted under this subsection.

(5) (a) An insurer shall not request, require, or purchase genetic information for underwriting purposes.

(b) An insurer shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the plan or coverage in connection with enrollment.

(c) If an insurer obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, the request, requirement, or purchase shall not be considered a violation of paragraph (b) of this subsection if the request, requirement, or purchase is not in violation of paragraph (a) of this subsection.

(6) Any reference in this section to genetic information concerning an individual or family member of an individual shall include:

(a) Genetic information of any fetus carried by such pregnant woman with respect to an individual or family member of an individual who is a pregnant woman; and

(b) Genetic information of any embryo legally held by the individual or family member, with respect to an individual or family member utilizing an assisted reproductive technology.

SECTION 3 A NEW SECTION OF SUBTITLE 12 OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) (a) A health insurer offering health insurance in the individual market may not establish rules for the eligibility, including continued eligibility, of any individual to enroll in individual health insurance based on genetic information.

(b) Nothing in paragraph (a) of this subsection or in Section 1(5)(a) or Section 1(5)(b) of this act shall be construed to preclude a health insurer from establishing rules for eligibility for an individual to enroll in individual health insurance based on the manifestation of a disease or disorder in that individual, or in a family member of the individual where the family member is covered under the policy that covers the individual.

(2) Prohibition on genetic information as pre-existing condition in the individual market

(a) A health insurer offering health insurance in the individual market shall not, on the basis of genetic information, impose any pre-existing condition exclusion, as defined and described in KRS 304.17A-220 and 304.17A-230 with respect to the coverage.

(b) Nothing in paragraph (a) of this section or in Section 1(5)(a) or Section 1(5)(b) of this act shall be construed to preclude a health insurer from imposing any pre-existing condition exclusion for an individual with respect to health insurance on the basis of a manifestation of a disease or disorder in that individual.

SECTION 4. A NEW SECTION OF SUBTITLE 99 OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) If a health insurer or agent is found by the executive director to be in violation of section 1, 2 or 3 of this act , the executive director may suspend, revoke or refuse to continue the health insurer's certificate of authority or the agent's license, impose a fine in accordance with KRS 304.99-020 or both.

Section 5. KRS 304.12-085 is amended to read as follows:

(1) No person shall, whether acting for himself or another in connection with an insurance transaction, fail or refuse to issue or renew insurance to any person because of race, color, religion, national origin, or sex except that rates determined through valid actuarial tables shall not be ***in violation*** [~~violative~~] of KRS Chapter 344.

(2) In the case of benefits consisting of medical care provided under, offered by, or in connection with a group or individual health benefit plan, the plan or insurer may not deny, cancel, or refuse to renew the benefits or coverage, or vary the premiums, terms, or conditions for the benefits or coverage, for any participant or beneficiary under the plan:

(a) On the basis of a genetic test, for which symptoms have not manifested; or

(b) On the basis that the participant or beneficiary has requested or received genetic services.

(3) A group or individual health benefit plan or insurer offering health insurance in connection with a health benefit plan or an insurer offering a disability income plan may not request or require an applicant, participant, or beneficiary to disclose to the plan or insurer any genetic test about the participant, beneficiary, or applicant.

(4) A group or individual health benefit plan or insurer offering health insurance in connection with a health benefit plan may not disclose any genetic test about a participant or beneficiary without prior authorization by the participant. The authorization is required for each disclosure.

(5) ***Discrimination based on genetic information as set forth in Section 1 through 4 of this act shall be prohibited.***

(6) For purposes of this section, unless the context requires otherwise:

(a) "Health benefit plan" has the meaning given it in KRS 304.17A-005; and

(b) "Insurer" has the meaning given it in KRS 304.17A-005.

Section 6. KRS 304.17-042 is amended to read as follows:

(1) All individual health insurance policies providing coverage on an expense incurred basis regardless of whether the policies are issued for nonfamily or family coverage, shall, provide that health insurance benefits shall be payable with respect to a newly born child of the insured from the moment of birth.

(2) The coverage for newly born children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

(3) If payment of a specific premium or fee is required to provide coverage for a child the policy or contract may require that notification of birth of a newly born child and payment of the required premium or fees must be furnished to the insurer within thirty-one (31) days after the date of birth in order to have the coverage continue beyond such thirty-one (31) day period.

(4) The requirements of this section shall apply to all health insurance policies delivered in this state on and after July 15, 1994.

(5) Discrimination based on genetic information as set forth in Section 1 through 4 of this act shall be prohibited.

Section 7. KRS 304.17-310 is amended to read as follows:

(1) Family expense health insurance is that provided under a policy issued to one (1) of the family members insured, who shall be deemed the policyholder, covering any two (2) or more eligible members of a family, including husband, wife, unmarried dependent children, to age nineteen (19), unmarried children from nineteen (19) to twenty-five (25) years of age who are full-time students enrolled in and attending an accredited educational institution and who are

primarily dependent on the policyholder for maintenance and support, and any other person dependent upon the policyholder. Any authorized health insurer may issue the insurance.

(2) An individual hospital or medical expense insurance policy or hospital or medical service plan contract delivered or issued for delivery in this state more than 120 days after June 13, 1968, which provides that coverage of a dependent child shall terminate upon attainment of the limiting age for dependent children specified in the policy or contract shall also provide in substance that attainment of the limiting age shall not operate to terminate the coverage of the child while the child is and continues to be both (a) incapable of self-sustaining employment by reason of mental retardation or physical disability and (b) chiefly dependent upon the policyholder or subscriber for support and maintenance, provided proof of the incapacity and dependency is furnished to the insurer or corporation by the policyholder or subscriber within thirty-one (31) days of the child's attainment of the limiting age and subsequently as may be required by the insurer or corporation but not more frequently than annually after the two (2) year period following the child's attainment of the limiting age.

(3) Insurers offering family expense health insurance shall offer the applicant the option to purchase coverage for unmarried dependent children until age twenty-five (25).

(4) (a) "Medically necessary leave of absence" means a leave of absence of a dependent child from an accredited educational institution, or any other change in enrollment of a dependent child at an accredited educational institution that:

1. Commences while the dependent child is suffering from a serious illness or injury;

2 Is medically necessary; and

3. Causes the dependent child to lose full-time student status for purposes of coverage under the terms of the family expense health insurance policy or contract.

(b) An insurer shall not terminate coverage of a dependent child under a family expense health insurance policy due to medically necessary leave of absence before the earlier of:

1. The date that is one (1) year after the first day of the medically necessary leave of absence; or

2. The date on which the coverage would otherwise terminate under the terms of the family expense health insurance policy.

(c) Paragraph (b) of this subsection shall apply only if the insurer has received written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury and that the leave of absence or other change of enrollment as described in paragraph (a) of this subsection is medically necessary.

(d) An insurer shall include with any notice regarding a requirement for certification of full-time student status for coverage under the family expense health insurance policy, a description of the terms of this subsection for coverage during a medically necessary leave of absence. This description shall be in clear and understandable terms for the policyholder.

(e) A dependent child shall be entitled to the same benefits during the medically necessary leave of absence as if the dependent child continued to be a full-time student

at the accredited educational institution and was not on a medically necessary leave of absence.

(f) If:

1. The manner in which a policyholder is covered under a family-expense health insurance policy changes, whether through a change in coverage or insurer or otherwise; and

2. The health insurance policy as so changed provides coverage of dependent children;

a dependent child of the policyholder that is on a medically necessary leave of absence at the time the policy changes shall continue to be considered a dependent child for the remainder of the period of the medically necessary leave of absence, in accordance with subsection (4)(b) of this section.

Section 8. KRS 304.17A-0952 is amended to read as follows:

Premium rates for a health benefit plan issued or renewed to an individual, a small group, or an association on or after April 10, 1998, shall be subject to the following provisions:

(1) The premium rates charged during a rating period to an individual with similar case characteristics for the same coverage, or the rates that could be charged to that individual under the rating system for that class of business, shall not vary from the index rate by more than thirty-five percent (35%) of the index rate upon any policy issuance or renewal, on or after January 1, 2003.

(2) Notwithstanding the thirty-five percent (35%) variance limitation in subsection (1) of this section, insurers offering an individual health benefit plan that is state-elected under sec. 35(e)(1)F of the Trade Act of 2002, Pub. L. No. 107-210 sec. 201, may vary from the index rate

by more than thirty-five percent (35%) for individuals who are eligible for the health coverage tax credit under the following conditions:

(a) The insurer certifies that the individual does not meet the insurer's underwriting guidelines for issuance of an individual policy;

(b) The policy meets the requirements for state-elected coverage under the Trade Act of 2002; and

(c) The premium rate is actuarially justified and has been approved by the Office of Insurance pursuant to KRS 304.17A-095.

(3) The percentage increase in the premium rate charged to an individual for a new rating period shall not exceed the sum of the following:

(a) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business for which the insurer is not issuing new policies, the insurer shall use the percentage change in the base premium rate;

(b) Any adjustment, not to exceed twenty percent (20%) annually and adjusted pro rata for rating periods of less than one (1) year, due to the claim experience, mental and physical condition, including medical condition, medical history, and health service utilization, or duration of coverage of the individual and dependents as determined from the insurer's rate manual for the class of business; and

(c) Any adjustment due to change in coverage or change in the case characteristics of the individual as determined from the insurer's rate manual for the class of business

(4) ***Discrimination based on genetic information as set forth in sections 1 through 4 of this act shall be prohibited***.

(5) The premium rates charged during a rating period to a small group or to an association member with similar case characteristics for the same coverage, or the rates that could be charged to that small group or that association member under the rating system for that class of business, shall not vary from the index rate by more than fifty percent (50%) of the index rate.

(6) [~~(5)~~] The percentage increase in the premium rate charged to a small group or to an association member for a new rating period shall not exceed the sum of the following:

(a) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business for which the insurer is not issuing new policies, the insurer shall use the percentage change in the base premium rate;

(b) Any adjustment, not to exceed twenty percent (20%) annually and adjusted pro rata for rating periods of less than one (1) year, due to the claims experience, mental and physical condition, including medical condition, medical history, and health service utilization, or duration of coverage of the employee, association member, or dependents as determined from the insurer's rate manual for the class of business; and

(c) Any adjustment due to change in coverage or change in the case characteristics of the small group or association member as determined from the insurer's rate manual for the class of business

(7) [~~(6)~~] In utilizing case characteristics, the ratio of the highest rate factor to the lowest rate factor within a class of business shall not exceed five to one (5:1). For purpose of this limitation, case characteristics include age, gender, occupation or industry, and geographic area.

(8) [~~(7)~~] Adjustments in rates for claims experience, mental and physical condition, including medical condition, medical history, and health service utilization, health status, and duration of

coverage shall not be charged to an individual group member or the member's dependents. Any adjustment shall be applied uniformly to the rates charged for all individuals and dependents of the small group.

(9) [~~(8)~~] The executive director may approve establishment of additional classes of business upon application to the executive director and a finding by the executive director that the additional class would enhance the efficiency and fairness for the applicable market segment.

(a) The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business in that market segment by more than ten percent (10%).

(b) An insurer may establish a separate class of business only to reflect substantial differences in expected claims experience or administrative cost related to the following reasons:

1. The insurer uses more than one (1) type of system for the marketing and sale of the health benefit plans;

2. The insurer has acquired a class of business from another insurer; or

3. The insurer is offering a state-elected plan under the provisions of the Trade Act of 2002, Pub. L. No. 107-210 sec. 201.

(c) Notwithstanding any other provision of this subsection, beginning January 1, 2001, a GAP participating insurer may establish a separate class of business for the purpose of separating guaranteed acceptance program qualified individuals from other individuals enrolled in their plan prior to January 1, 2001. The index rate for the separate class created under this paragraph shall be established taking into consideration expected

claims experience and administrative costs of the new class of business and the previous class of business.

(10) [~~(9)~~] For the purpose of this section, a health benefit plan that utilizes a restricted provider network shall not be considered similar coverage to a health benefit plan that does not utilize a restricted provider network if utilization of the restricted provider network results in substantial differences in claims costs.

(11) [~~(10)~~] Notwithstanding any other provision of this section, an insurer shall not be required to utilize the experience of those individuals with high-cost conditions who enrolled in its plans between July 15, 1995, and April 10, 1998, to develop the insurer's index rate for its individual policies.

(12) [~~(11)~~] Nothing in this section shall be construed to prevent an insurer from offering incentives to participate in a program of disease prevention or health improvement.

Section 9. KRS 304.17A-0954 is amended to read as follows:

(1) For purposes of this section:

(a) "Base premium rate" has the meaning provided in KRS 304.17A-005;

(b) "Employer" means a person engaged in a trade or business who has two (2) or more employees within the state in each of twenty (20) or more calendar weeks in the current or preceding calendar year;

(c) "Employer-organized association" means any of the following:

1. Any entity which was qualified by the executive director as an eligible association prior to April 10, 1998, and which has actively marketed a health insurance program to its members after September 8, 1996, and which is not insurer-controlled;

2. An entity organized under KRS 247.240 to 247.370 that has actively marketed health insurance to its members and which is not insurer-controlled; or

3. Any entity which is a bona fide association as defined in 42 U.S.C. sec. 300gg-91(d)(3), whose members consist principally of employers, and for which the entity's health insurance decisions are made by a board or committee the majority of which are representatives of employer members of the entity who obtain group health insurance coverage through the entity or through a trust or other mechanism established by the entity, and whose health insurance decisions are reflected in written minutes or other written documentation;

(d) "Index rate" has the meaning provided in KRS 304.17A-005.

(2) Notwithstanding any other provision of this chapter, the amount or rate of premiums for an employer-organized association health plan may be determined, subject to the restrictions of subsection (3) of this section, based upon the experience or projected experience of the employer-organized associations whose employers obtain group coverage under the plan. Without the written consent of the employer-organized association filed with the executive director, the index rate for the employer-organized association shall be calculated solely with respect to that employer-organized association and shall not be tied to, linked to, or otherwise adversely affected by any other index rate used by the issuing insurer.

(3) The following restrictions shall be applied in calculating the permissible amount or rate of premiums for an employer-organized health insurance plan:

(a) The premium rates charged during a rating period to members of the employer-organized association with similar characteristics for the same or similar coverage, or the premium rates that could be charged to a member of the employer-organized association

under the rating system for that class of business, shall not vary from its own index rate by more than fifty percent (50%) of its own index rate.

(b) The percentage increase in the premium rate charged to an employer member of an employer-organized association for a new rating period shall not exceed the sum of the following:

1. The percentage change in the new business premium rate for the employer-organized association measured from the first day of the prior rating period to the first day of the new rating period;

2. Any adjustment, not to exceed twenty percent (20%) annually and adjusted pro rata for rating period of less than one (1) year, due to the claims experience, mental and physical condition, including medical condition, medical history, and health service utilization, or duration of coverage of the member as determined from the insurer's rate manual; and

3. Any adjustment due to change in coverage or change in the case characteristics of the member as determined by the insurer's rate manual.

(4) ***Discrimination based on genetic information as set forth in sections 1 through 4 of this act shall be prohibited.***

(5) In utilizing case characteristics, the ratio of the highest rate factor to the lowest rate factor within a class of business shall not exceed five to one (5:1). For purpose of this limitation, case characteristics include age, gender, occupation or industry, and geographic area.

(6) [~~(5)~~] For the purpose of this section, a health insurance contract that utilizes a restricted provider network shall not be considered similar coverage to a health insurance contract that

does not utilize a restricted provider network if utilization of the restricted provider network results in measurable differences in claims costs.

Section 10. KRS 304.17A-139 is amended to read as follows:

(1) A health benefit plan that provides coverage for a family or dependent shall provide coverage of a newly born child of the insured from the moment of birth.

(2) Coverage for a newly born child shall consist of coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

(3) If payment of a specific premium or fee is required to provide coverage for a child, the policy or contract may require that notification of birth of a newly born child and payment of the required premium or fees must be furnished to the insurer within thirty-one (31) days after the date of birth in order to have the coverage continue beyond that thirty-one (31) day period.

(4) Discrimination based on genetic information as set forth in sections 1 through 4 of this act shall be prohibited.

Section 11. KRS 304.17A-145 is amended to read as follows:

(1) A health benefit plan issued or renewed on or after July 15, 1996, that provides maternity coverage shall provide coverage for inpatient care for a mother and her newly-born child for a minimum of forty-eight (48) hours after vaginal delivery and a minimum of ninety-six (96) hours after delivery by Cesarean section.

(2) The provisions of subsection (1) of this section shall not apply to a health benefit plan if the health benefit plan authorizes an initial postpartum home visit which would include the collection of an adequate sample for the hereditary and metabolic newborn screening and if the attending physician, with the consent of the mother of the newly-born child, authorizes a shorter

length of stay than that required of health benefit plans in subsection (1) of this section upon the physician's determination that the mother and newborn meet the criteria for medical stability in the most current version of "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists.

(3) Discrimination based on genetic information as set forth in sections 1 through 4 of this act shall be prohibited.

Section 12. KRS 304.17A-200 is amended to read as follows:

(1) An insurer that offers health benefit plan coverage in the small group, large group, or association market may not establish rules for eligibility of any individual to enroll under the terms of the plan based on any of the following health status-related factors in relation to the individual or the dependent of the individual:

(a) Health status;

(b) Medical condition, including both physical and mental illness;

(c) Claims experience;

(d) Receipt of health care;

(e) Medical history;

(f) Genetic information***, as defined in section 1 of this act***;

(g) Evidence of insurability, including conditions arising out of acts of domestic violence; and

(h) Disability.

(2) An insurer that offers health benefit plan coverage in the small group, large group, or association market shall not require any individual to pay a premium or contribution which is greater than the premium or contribution for a similarly situated individual enrolled in the plan

on the basis of any health status-related factor in relation to the individual or a dependent of the individual. Nothing in this subsection shall prevent the insurer from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

(3) Subject to subsections (4) to (7) of this section, each insurer that offers health benefit plan coverage in the small groups market shall accept every small employer that applies for coverage and shall accept for enrollment under this coverage every individual eligible for the coverage who applies for enrollment during the period in which the individual first becomes eligible to enroll under the terms of the group health benefit plan.

(a) Notwithstanding any other provision of this subsection, the insurer may establish group participation rules requiring a minimum number of participants or beneficiaries that must be enrolled in relation to a specified percentage or number of those eligible for enrollment.

(b) The terms and participation rules of the group health benefit plan shall be uniformly applicable to small employers in the small group market.

(c) This subsection shall not apply to health benefit plan coverage offered by an insurer if the coverage is made available in the small group market only through one (1) or more bona fide associations.

(4) In the case of an insurer that offers health benefit plan coverage in the small group market through a network plan, the insurer may:

(a) Limit the employers that may apply for coverage to those with individuals who live, work, or reside in the service area of the network plan; and

(b) Within the service area of the network plan, deny coverage to employers if the insurer has demonstrated to the executive director that:

1. The network plan will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contract holders and enrollees; and

2. The insurer is applying this denial uniformly to all employers.

(5) An insurer, upon denying health benefit plan coverage in any service area in accordance with subsection (4) of this section, shall not offer coverage in the small group market within the service area for a period of one hundred eighty (180) days after the date the coverage is denied.

(6) An insurer may deny health benefit plan coverage in the small group market if the insurer has demonstrated to the executive director that:

(a) The insurer does not have the financial reserves necessary to underwrite additional coverage; and

(b) The insurer is applying this denial uniformly to all employers in the small group market.

(7) An insurer, upon denying health benefit plan coverage in connection with group health plans in accordance with subsection (6) of this section, shall not offer coverage in the small group market for a period of one hundred eighty (180) days after the date the coverage is denied or until the insurer has demonstrated to the executive director that the insurer has sufficient financial reserves to underwrite additional coverage, whichever is later.

(8) A health benefit plan issued as an individual policy to individual employees or their dependents through or with the permission of a small employer shall be issued on a guaranteed-

issue basis to all full-time employees and shall comply with the pre-existing condition provisions of KRS 304.17A-220.

(9) (a) In connection with the offering of any health benefit plan to a small employer, an insurer:

1. Shall make a reasonable disclosure to a small employer, as part of its solicitation and sales materials, of the availability of information described in paragraph (b) of this subsection; and

2. Upon request of a small employer, provide the information described in paragraph (b) of this subsection.

(b) Subject to paragraph (c) of this subsection, with respect to an insurer offering a health benefit plan to a small employer, information described in this subsection is information concerning:

1. The provisions of the coverage concerning the insurer's right to change premium rates and the factors that may affect changes in premium rates;

2. The provisions of the health benefit plan relating to renewability of coverage;

3. The provisions of the health benefit plan relating to any ***pre-existing*** [~~preexisting~~] condition exclusion; and

4. The benefits and premiums available under all health benefit plans for which the small employer is qualified.

(c) Information described in paragraph (b) of this subsection shall be provided to a small employer in a manner determined to be understandable by the average small

employer and shall be sufficient to reasonably inform a small employer of his or her rights and obligations under the health benefit plan.

(d) An insurer is not required under this section to disclose any information that is proprietary and trade secret information under applicable law.

Section 13. KRS 304.17A-220 is amended to read as follows:

(1) All group health plans and insurers offering group health insurance coverage in the Commonwealth shall comply with the provisions of this section.

(2) Subject to subsection (8) of this section, a group health plan, and a health insurance insurer offering group health insurance coverage, may, with respect to a participant or beneficiary, impose a pre-existing condition exclusion only if:

(a) The exclusion relates to a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six (6) month period ending on the enrollment date. For purposes of this paragraph:

1. Medical advice, diagnosis, care, or treatment is taken into account only if it is recommended by, or received from, an individual licensed or similarly authorized to provide such services under state law and operating within the scope of practice authorized by state law; and

2. The six (6) month period ending on the enrollment date begins on the six (6) month anniversary date preceding the enrollment date;

(b) The exclusion extends for a period of not more than twelve (12) months, or eighteen (18) months in the case of a late enrollee, after the enrollment date;

(c) 1. The period of any pre-existing condition exclusion that would otherwise apply to an individual is reduced by the number of days of creditable coverage the individual has as of the enrollment date, as counted under subsection (3) of this section; and

2. Except for ***non-federally eligible*** **[**~~ineligible~~] individuals who apply for coverage in the individual market, the period of any pre-existing condition exclusion that would otherwise apply to an individual may be reduced by the number of days of creditable coverage the individual has as of the effective date of coverage under the policy; and

(d) A written notice of the pre-existing condition exclusion is provided to participants under the plan, and the insurer cannot impose a pre-existing condition exclusion with respect to a participant or a dependent of the participant until such notice is provided.

(3) In reducing the pre-existing condition exclusion period that applies to an individual, the amount of creditable coverage is determined by counting all the days on which the individual has one (1) or more types of creditable coverage. For purposes of counting creditable coverage:

(a) If on a particular day the individual has creditable coverage from more than one (1) source, all the creditable coverage on that day is counted as one (1) day;

(b) Any days in a waiting period for coverage are not creditable coverage;

(c) Days of creditable coverage that occur before a significant break in coverage are not required to be counted; and

(d) Days in a waiting period and days in an affiliation period are not taken into account in determining whether a significant break in coverage has occurred.

(4) An insurer may determine the amount of creditable coverage in another manner than established in subsection (3) of this section that is at least as favorable to the individual as the method established in subsection (3) of this section.

(5) If an insurer receives creditable coverage information, the insurer shall make a determination regarding the amount of the individual's creditable coverage and the length of any pre-existing exclusion period that remains. A written notice of the length of the pre-existing condition exclusion period that remains after offsetting for prior creditable coverage shall be issued by the insurer. An insurer may not impose any limit on the amount of time that an individual has to present a certificate or evidence of creditable coverage.

(6) For purposes of this section:

(a) "Pre-existing condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the effective date of coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. A pre-existing condition exclusion includes any exclusion applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage under a health benefit plan;

(b) "Enrollment date" means, with respect to an individual covered under a group health plan or health insurance coverage, the first day of coverage or, if there is a waiting period, the first day of the waiting period. If an individual receiving benefits under a group health plan changes benefit packages, or if the employer changes its group health insurer, the individual's enrollment date does not change;

(c) "First day of coverage" means, in the case of an individual covered for benefits under a group health plan, the first day of coverage under the plan and, in the case of an individual covered by health insurance coverage in the individual market, the first day of coverage under the policy or contract;

(d) "Late enrollee" means an individual whose enrollment in a plan is a late enrollment;

(e) "Late enrollment" means enrollment of an individual under a group health plan other than:

1. On the earliest date on which coverage can become effective for the individual under the terms of the plan; or

2. Through special enrollment;

(f) "Significant break in coverage" means a period of sixty-three (63) consecutive days during each of which an individual does not have any creditable coverage; and

(g) "Waiting period" means the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of a group health plan can become effective. If an employee or dependent enrolls as a late enrollee or special enrollee, any period before such late or special enrollment is not a waiting period. If an individual seeks coverage in the individual market, a waiting period begins on the date the individual submits a substantially complete application for coverage and ends on:

1. If the application results in coverage, the date coverage begins; or

2. If the application does not result in coverage, the date on which the application is denied by the insurer or the date on which the offer of coverage lapses.

(7) (a) 1. Except as otherwise provided under subsection (3) of this section, for purposes of applying subsection (2)(c) of this section, a group health plan, and a health insurance insurer offering group health insurance coverage, shall count a period of creditable coverage without regard to the specific benefits covered during the period.

2. A group health plan, or a health insurance insurer offering group health insurance coverage, may elect to apply subsection (2)(c) of this section based on coverage of benefits within each of several classes or categories of benefits specified in federal regulations. This election shall be made on a uniform basis for all participants and beneficiaries. Under this election, a group health plan or insurer shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within this class or category.

3. In the case of an election with respect to a group health plan under subparagraph 2. of this paragraph, whether or not health insurance coverage is provided in connection with the plan, the plan shall:

a. Prominently state in any disclosure statements concerning the plan, and state to each enrollee at the time of enrollment under the plan, that the plan has made this election; and

b. Include in these statements a description of the effect of this election.

(b) Periods of creditable coverage with respect to an individual shall be established through presentation of certifications described in subsection (9) of this section or in such other manner as may be specified in administrative regulations.

(8) (a) Subject to paragraph (e) of this subsection, a group health plan, and a health insurance insurer offering group health insurance coverage, may not impose any pre-existing condition exclusion on a child who, within thirty (30) days after birth, is covered under any creditable coverage. If a child is enrolled in a group health plan or other creditable coverage within thirty (30) days after birth and subsequently enrolls in another group health plan without a significant break in coverage, the other group health plan may not impose any pre-existing condition exclusion on the child.

(b) Subject to paragraph (e) of this subsection, a group health plan, and a health insurance insurer offering group health insurance coverage, may not impose any pre-existing condition exclusion on a child who is adopted or placed for adoption before attaining eighteen (18) years of age and who, within thirty (30) days after the adoption or placement for adoption, is covered under any creditable coverage. If a child is enrolled in a group health plan or other creditable coverage within thirty (30) days after adoption or placement for adoption and subsequently enrolls in another group health plan without a significant break in coverage, the other group health plan may not impose any pre-existing condition exclusion on the child. This shall not apply to coverage before the date of the adoption or placement for adoption.

(c) A group health plan may not impose any pre-existing condition exclusion relating to pregnancy.

(d) A group health plan may not impose a pre-existing condition exclusion relating to a condition based solely on genetic information ***as defined in section 1 of this act***. If an individual is diagnosed with a condition, even if the condition relates to genetic information, the insurer may impose a pre-existing condition exclusion with respect to the condition, subject to other requirements of this section.

(e) Paragraphs (a) and (b) of this subsection shall no longer apply to an individual after the end of the first sixty-three (63) day period during all of which the individual was not covered under any creditable coverage.

(9) (a) 1. group health plan, and a health insurance insurer offering group health insurance coverage, shall provide a certificate of creditable coverage as described in subparagraph 2. of this subsection. A certificate of creditable coverage shall be provided, without charge, for participants or dependents who are or were covered under a group health plan upon the occurrence of any of the following events:

a. At the time an individual ceases to be covered under a health benefit plan or otherwise becomes eligible under a COBRA continuation provision;

b. In the case of an individual becoming covered under a COBRA continuation provision, at the time the individual ceases to be covered under the COBRA continuation provision; and

c. On request on behalf of an individual made not later than twenty-four (24) months after the date of cessation of the coverage described in subdivision a. or b. of this subparagraph, whichever is later.

The certificate of creditable coverage as described under subdivision a. of this subparagraph may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

2. The certification described in this subparagraph is a written certification of:

a. The period of creditable coverage of the individual under the health benefit plan and the coverage, if any, under the COBRA continuation provision; and

b. The waiting period, if any, and affiliation period, if applicable, imposed with respect to the individual for any coverage under the plan.

3. To the extent that medical care under a group health plan consists of group health insurance coverage, the plan is deemed to have satisfied the certification requirement under this paragraph if the health insurance insurer offering the coverage provides for the certification in accordance with this paragraph.

(b) In the case of an election described in subsection (7)(a)2. of this section by a group health plan or health insurance insurer, if the plan or insurer enrolls an individual for coverage under the plan and the individual provides a certification of coverage of the individual under paragraph (a) of this subsection:

1. Upon request of that plan or insurer, the entity that issued the certification provided by the individual shall promptly disclose to the requesting plan or

insurer information on coverage of classes and categories of health benefits available under the entity's plan or coverage; and

2. The entity may charge the requesting plan or insurer for the reasonable cost of disclosing this information.

(10) (a) A group health plan, and a health insurance insurer offering group health insurance coverage in connection with a group health plan, shall permit an employee who is eligible but not enrolled for coverage under the terms of the plan, or a dependent of that employee if the dependent is eligible but not enrolled for coverage under these terms, to enroll for coverage under the terms of the plan if each of the following conditions is met:

1. The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent;

2. The employee stated in writing at that time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or insurer, if applicable, required that statement at that time and provided the employee with notice of the requirement, and the consequences of the requirement, at that time;

3. The employee's or dependent's coverage described in subparagraph 1. of this paragraph:

a. Was under a COBRA continuation provision and the coverage under that provision was exhausted; or

b. Was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage, including as a

result of legal separation, divorce, cessation of dependent status, such as obtaining the maximum age to be eligible as a dependent child, death of the employee, termination of employment, reduction in the number of hours of employment, employer contributions toward the coverage were terminated, a situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits, or a situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual; or

c. Was offered through a health maintenance organization or other arrangement in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area and, loss of coverage in the group market occurred because an individual no longer resides, lives, or works in the service area, whether or not within the choice of the individual, and no other benefit package is available to the individual; and

4. An insurer shall allow an employee and dependent a period of at least thirty (30) days after an event described in this paragraph has occurred to request enrollment for the employee or the employee's dependent. Coverage shall begin no later than the first day of the first calendar month beginning after the date the insurer receives the request for special enrollment.

(b) A dependent of a current employee, including the employee's spouse, and the employee each are eligible for enrollment in the group health plan subject to plan

eligibility rules conditioning dependent enrollment on enrollment of the employee if the requirements of paragraph (a) of this subsection are satisfied.

(c) 1. If:

a. A group health plan makes coverage available with respect to a dependent of an individual;

b. The individual is a participant under the plan, or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period; and

c. A person becomes such a dependent of the individual through marriage, birth, or adoption or placement for adoption;

the group health plan shall provide for a dependent special enrollment period described in subparagraph 2. of this paragraph during which the person or, if not otherwise enrolled, the individual, may be enrolled under the plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if the spouse is otherwise eligible for coverage.

2. A dependent special enrollment period under this subparagraph shall be a period of at least thirty (30) days and shall begin on the later of:

a. The date dependent coverage is made available; or

b. The date of the marriage, birth, or adoption or placement for adoption, as the case may be, described in subparagraph 1.c. of this paragraph.

3. If an individual seeks to enroll a dependent during the first thirty (30) days of the dependent special enrollment period, the coverage of the dependent shall become effective:

a. In the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

b. In the case of a dependent's birth, as of the date of the birth; or

c. In the case of a dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

(d) ***A group health plan shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan, or a dependent of the employee if the dependent is eligible but not enrolled, for coverage under the terms of the plan, to enroll for coverage if either of the following conditions is met:***

1. The employee or dependent is covered under a Medicaid plan under title XIX of the Social Security Act or under the state child health plan under title XXI of the Act and coverage of the employee or dependent under such plan is terminated as a result of loss of eligibility for such coverage and the employee request coverage under the group health plan not later than sixty (60) days after the date of termination of such coverage; or

2. The employee or dependent becomes eligible for assistance, with respect to coverage under the group health plan, under such Medicaid plan or state child health plan, including any waiver or demonstration project conducted under or in relation to such a plan, if the employee requests coverage under the group health plan not later than sixty (60) days after the date the employee or dependent is determined to be eligible for such assistance.

(e) At or before the time an employee is initially offered the opportunity to enroll in a group health plan, the employer shall provide the employee with a notice of special enrollment rights.

(11) (a) In the case of a group health plan that offers medical care through health insurance coverage offered by a health maintenance organization, the plan may provide for an affiliation period with respect to coverage through the organization only if:

1. No pre-existing condition exclusion is imposed with respect to coverage through the organization;

2. The period is applied uniformly without regard to any health status-related factors; and

3. The period does not exceed two (2) months, or three (3) months in the case of a late enrollee.

(b) 1. For purposes of this section, the term "affiliation period" means a period which, under the terms of the health insurance coverage offered by the health maintenance organization, must expire before the health insurance coverage becomes effective. The organization is not required to provide health care services or benefits

during this period and no premium shall be charged to the participant or beneficiary for any coverage during the period.

2. This period shall begin on the enrollment date.

3. An affiliation period under a plan shall run concurrently with any waiting period under the plan.

(c) A health maintenance organization described in paragraph (a) of this subsection may use alternative methods other than those described in that paragraph to address adverse selection as approved by the executive director.

Section 14. KRS 304.17A-230 is amended to read as follows:

(1) A health insurer offering individual health benefit plan coverage in the individual market in the Commonwealth shall not impose any pre-existing conditions exclusions as to any eligible individual.

(2) Each health insurer offering individual health benefit plan coverage in the individual market in the Commonwealth that chooses to impose a pre-existing conditions exclusion on individuals who do not meet the definition of eligible individual shall comply with the provisions of KRS 304.17A-220, which establishes standards and requirements for pre-existing conditions exclusions for group health plans, including crediting previous coverage, and certification of coverage. Pregnancy may be considered to be a pre-existing condition.

(3) Genetic information***, as set forth in this section 1 of this act,*** shall not be treated as a pre-existing condition in the absence of a diagnosis of the condition related to the information.

(4) The Office of Insurance shall promulgate administrative regulations necessary to carry out the provisions of this section and KRS 304.17A-220.

Section 15. KRS 304.17A-250 is amended to read as follows:

(1) The executive director shall, by administrative regulations promulgated under KRS Chapter 13A, define one (1) standard health benefit plan. After July 15, 2004, insurers may offer the standard health benefit plan in the individual or small group markets. Except as may be necessary to coordinate with changes in federal law, the executive director shall not alter, amend, or replace the standard health benefit plan more frequently than annually.

(2) If offered, the standard health benefit plan may be available in at least one (1) of these four (4) forms of coverage:

(a) A fee-for-service product type;

(b) A health maintenance organization type;

(c) A point-of-service type; and

(d) A preferred provider organization type.

(3) The standard health benefit plan shall be defined so that it meets the requirements of KRS 304.17B-021 for inclusion in calculating assessments and refunds under Kentucky Access.

(4) Any health insurer who offers the standard health benefit plan may offer the standard health benefit plan in the individual or small group markets in each and every form of coverage that the health insurer offers to sell.

(5) Nothing in this section shall be construed:

(a) To require a health insurer to offer a standard health benefit plan in a form of coverage that the health insurer has not selected;

(b) To prohibit a health insurer from offering other health benefit plans in the individual or small group markets in addition to the standard health benefit plan; or

(c) To require that a standard health benefit plan have guaranteed issue, renewability, or pre-existing condition exclusion rights or provisions that are more generous to the

applicant than the health insurer would be required to provide under KRS 304.17A-200, 304.17A-220, 304.17A.230, and 304.17A-240.

(6) ***Except as provided by federal law,*** all health benefit plans shall cover hospice care at least equal to the Medicare benefits.

(7) All health benefit plans shall coordinate benefits with other health benefit plans in accordance with the guidelines for coordination of benefits prescribed by the executive director as provided in KRS 304.18-085.

(8) Every health insurer of any kind, nonprofit hospital, medical-surgical, dental and health service corporation, health maintenance organization, or provider-sponsored health delivery network that issues or delivers an insurance policy in this state that directs or gives any incentives to insureds to obtain health care services from certain health care providers shall not imply or otherwise represent that a health care provider is a participant in or an affiliate of an approved or selected provider network unless the health care provider has agreed in writing to the representation or there is a written contract between the health care provider and the insurer or an agreement by the provider to abide by the terms for participation established by the insurer. This requirement to have written contracts shall apply whenever an insurer includes a health care provider as a part of a preferred provider network or otherwise selects, lists, or approves certain health care providers for use by the insurer's insureds. The obligation set forth in this section for an insurer to have written contracts with providers selected for use by the insurer shall not apply to emergency or out-of-area services.

(9) A self-insured plan may select any third party administrator licensed under KRS 304.9-052 to adjust or settle claims for persons covered under the self-insured plan.

(10) Any health insurer that fails to issue a premium rate quote to an individual within thirty (30) days of receiving a properly completed application request for the quote shall be required to issue coverage to that individual and shall not impose any pre-existing conditions exclusion on that individual with respect to the coverage. Each health insurer offering individual health insurance coverage in the individual market in the Commonwealth that refuses to issue a health benefit plan to an applicant or insured with a disclosed high-cost condition as specified in KRS 304.17B-001 or for any reason, shall provide the individual with a denial letter within twenty (20) working days of the request for coverage. The letter shall include the name and title of the person making the decision, a statement setting forth the basis for refusing to issue a policy, a description of Kentucky Access, and the telephone number for a contact person who can provide additional information about Kentucky Access.

(11) If a standard health benefit plan covers services that the plan's insureds lawfully obtain from health departments established under KRS Chapter 212, the health insurer shall pay the plan's established rate for those services to the health department.

(12) No individually insured person shall be required to replace an individual policy with group coverage on becoming eligible for group coverage that is not provided by an employer. In a situation where a person holding individual coverage is offered or becomes eligible for group coverage not provided by an employer, the person holding the individual coverage shall have the option of remaining individually insured, as the policyholder may decide. This shall apply in any such situation that may arise through an association, an affiliated group, the Kentucky state employee health insurance plan, or any other entity.

Section 16. KRS 304.17A-256 is amended to read as follows:

(1) All group health benefit plans which provide dependent benefits shall offer the master policyholder the following two (2) options to purchase coverage for an unmarried dependent child:

(a) Coverage until age nineteen (19) and coverage to unmarried children from nineteen (19) to twenty-five (25) years of age who are full-time students enrolled in and attending an accredited educational institution and who are primarily dependent on the policyholder for maintenance and support; and

(b) Coverage until age twenty-five (25).

(2) The offer of coverage under paragraph (b) of subsection (1) of this section shall include a disclaimer that selecting either option may have tax implications.

(3) (a) "Medically necessary leave of absence" means a leave of absence of a dependent child from an accredited educational institution, or any other change in enrollment of a dependent child at an accredited educational institution that:

1. Commences while the dependent child is suffering from a serious illness or injury;

2 Is medically necessary; and

3. Causes the dependent child to lose full-time student status for purposes of coverage under the terms of the group health benefit plan.

(b) An insurer shall not terminate coverage of a dependent child under a group health benefit plan due to medically necessary leave of absence before the earlier of:

1. The date that is one (1) year after the first day of the medically necessary leave of absence; or

2. The date on which the coverage would otherwise terminate under the terms of the family expense health insurance policy.

(c) Paragraph (b) of this subsection shall apply only if the insurer has received written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury and that the leave of absence or other change of enrollment as described in paragraph (a) of this subsection is medically necessary.

(d) An insurer shall include with any notice regarding a requirement for certification of full-time student status for coverage under the group health benefit plan, a description of the terms of this subsection for coverage during a medically necessary leave of absence. This description shall be in clear and understandable terms for the policyholder.

(e) A dependent child shall be entitled to the same benefits during the medically necessary leave of absence as if the dependent child continued to be a full-time student at the accredited educational institution and was not on a medically necessary leave of absence.

(f) If:

1. The manner in which a member is covered under a group health benefit plan changes, whether through a change in coverage or insurer or otherwise; and

2. The group health benefit plan as so changed provides coverage of dependent children;

a dependent child of the member that is on a medically necessary leave of absence at the time the policy changes shall continue to be considered a dependent child for the remainder of the period of the medically necessary leave of absence, in accordance with subsection (3)(b) of this section .

SECTION 17. A NEW SECTION OF SUBTITLE 18 OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

For purposes of section 17 through section 23 of this act:

(1) "Aggregate lifetime limit" means, with respect to benefits covered under a group health insurance policy or certificate, a dollar limitation on the total amount that may be paid with respect to the benefits under the policy or certificate.

(2) "Annual limit" means, with respect to benefits covered under a group health insurance policy or certificate, a dollar limitation on the total amount of benefits that may be paid with respect to the benefits in a 12-month period under the policy or certificate.

(3) "Financial requirement" means deductibles, copayments, coinsurance, other cost-sharing requirements, and out-of-pocket expenses, but excludes an aggregate lifetime limit and an annual limit subject to section 18 of this act.

(4) "Medical or surgical benefits" means benefits with respect to medical or surgical services, as defined under the terms of the insurance policy or certificate, but does not include mental health or substance use disorder benefits.

(5) "Mental health or substance use disorder benefits" means benefits with respect to services, including any necessary outpatient, inpatient ,rehabilitation, residential, partial hospitalization, day treatment, emergency detoxification, or crisis stabilization services for mental health conditions, as defined as any condition or disorder that falls under any of the

diagnostic categories listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders or that is listed in the mental disorders section of the international classification of disease.

(6) "Treatment limitation" means limits on the frequency of treatment, number of visits, days of coverage, prescription coverage, or other similar limits on the scope or duration of treatment.

SECTION 18. A NEW SECTION OF SUBTITLE 18 OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) (a) A group health insurance policy or certificate shall not place a greater restriction on mental health or substance use disorder benefits than the least restrictive or limited benefit for medical and surgical benefits.

(b) The restriction referenced in subsection (1) of this section shall include:

1. An aggregate lifetime limit;

2. An annual limit:

3. A financial requirement; or

4. A treatment limitation.

(2) Expenses for mental health and physical health conditions shall be combined for purposes of meeting deductible and out-of-pocket limits required under a health insurance policy or certificate.

(3) (a) The criteria for medical necessity determinations made under the policy or certificate with respect to mental health or substance use disorder benefits, or the health insurance offered in connection with the policy or certificate with respect to such benefits, shall be made available by the health insurer offering such coverage, in

accordance with administrative regulations to any applicant, covered person, or contracting provider upon request.

(b) The reason for any denial of reimbursement or payment for services under the insurance policy or certificate with respect to mental health or substance use disorder benefits shall be provided by health insurer offering such coverage, to the covered person.

(4) In the case of a policy or certificate that provides both medical and surgical benefits and mental health or substance use disorder benefits, if the policy or certificate provides coverage for medical or surgical benefits provided by out-of-network providers, the policy or certificate shall provide coverage for mental health or substance use disorder benefits provided by out-of-network providers in a manner that is consistent with the requirements of this section.

(5) Nothing in this section shall be construed:

(a) As requiring a group health insurance policy or certificate to provide any mental health or substance use disorder benefits; or

(b) In the case of a group health insurance policy or certificate that provides mental health or substance use disorder benefits, as affecting the terms and conditions of the policy or certificate relating to the benefits under the plan or coverage, except as provided in subsection (1) of this section.

(6) This section shall not apply to any small group as defined in KRS 304.17A-005.

(7) A violation of this section shall constitute an act of discrimination and shall be an unfair trade practice under this chapter. The remedies provided under KRS 304.99-020 shall apply to conduct in violation of this section.

Section 19. KRS 304.17A-505 is amended to read as follows:

An insurer shall disclose in writing to a covered person and an insured or enrollee, in a manner consistent with the provisions of KRS 304.14-420 to 304.14-450, the terms and conditions of its health benefit plan and shall promptly provide the covered person and enrollee with written notification of any change in the terms and conditions prior to the effective date of the change. The insurer shall provide the required information at the time of enrollment and upon request thereafter.

(1) The information required to be disclosed under this section shall include a description of:

(a) Covered services and benefits to which the enrollee or other covered person is entitled;

(b) Restrictions or limitations on covered services and benefits;

(c) Financial responsibility of the covered person, including copayments and deductibles;

(d) Prior authorization and any other review requirements with respect to accessing covered services;

(e) Where and in what manner covered services may be obtained;

(f) Changes in covered services or benefits, including any addition, reduction, or elimination of specific services or benefits;

(g) The covered person's right to the following:

1. A utilization review and the procedure for initiating a utilization review, if an insurer elects to provide utilization review;

2. An internal appeal of a utilization review made by or on behalf of the insurer with respect to the denial, reduction, or termination of a health care benefit

or the denial of payment for a health care service, and the procedure to initiate an internal appeal; and

3. An external review and the procedure to initiate the external review process;

(h) Measures in place to ensure the confidentiality of the relationship between an enrollee and a health care provider;

(i) Other information as the executive director shall require by administrative regulation;

(j) A summary of the drug formulary, including, but not limited to, a listing of the most commonly used drugs, drugs requiring prior authorization, any restrictions, limitations, and procedures for authorization to obtain drugs not on the formulary and, upon request of an insured or enrollee, a complete drug formulary; [~~and~~]

(k) A statement informing the insured or enrollee that if the provider meets the insurer's enrollment criteria and is willing to meet the terms and conditions for participation, the provider has the right to become a provider for the insurer***; and***

(l) The availability to obtain the criteria for medical necessity determinations made under the health benefit plan plan with respect to mental health or substance use disorder benefits in accordance with section 18(3) of this act.

(2) The insurer shall file the information required under ***subsection (1)(a) through (k) of*** this section with the office.

(3) The information required under subsection (1)(l) of this section shall be made available to any applicant or covered person, or contracting provider upon request.

Section 20. KRS 304.17A-607 is amended to read as follows:

(1) An insurer or private review agent shall not provide or perform utilization reviews without being registered with the office. A registered insurer or private review agent shall:

(a) Have available the services of sufficient numbers of registered nurses, medical records technicians, or similarly qualified persons supported by licensed physicians with access to consultation with other appropriate physicians to carry out its utilization review activities;

(b) Ensure that only licensed physicians shall:

1. Make a utilization review decision to deny, reduce, limit, or terminate a health care benefit or to deny, or reduce payment for a health care service because that service is not medically necessary, experimental, or investigational except in the case of a health care service rendered by a chiropractor or optometrist where the denial shall be made respectively by a chiropractor or optometrist duly licensed in Kentucky; and

2. Supervise qualified personnel conducting case reviews;

(c) Have available the services of sufficient numbers of practicing physicians in appropriate specialty areas to assure the adequate review of medical and surgical specialty and subspecialty cases;

(d) Not disclose or publish individual medical records or any other confidential medical information in the performance of utilization review activities except as provided in the Health Insurance Portability and Accountability Act, Subtitle F, secs. 261 to 264 and 45 C.F.R. secs. 160 to 164 and other applicable laws and administrative regulations;

(e) Provide a toll free telephone line for covered persons, authorized persons, and providers to contact the insurer or private review agent and be accessible to covered

persons, authorized persons, and providers for forty (40) hours a week during normal business hours in this state;

(f) Where an insurer, its agent, or private review agent provides or performs utilization review, be available to conduct utilization review during normal business hours and extended hours in this state on Monday and Friday through 6:00 p.m., including federal holidays;

(g) Provide decisions to covered persons, authorized persons, and all providers on appeals of adverse determinations and coverage denials of the insurer or private review agent, in accordance with this section***, Section 18(3)(b) of this act,*** and administrative regulations promulgated in accordance with KRS 304.17A-609;

(h) Except for retrospective review of an emergency admission where the covered person remains hospitalized at the time the review request is made, which shall be considered a concurrent review, provide a utilization review decision relating to urgent and nonurgent care in accordance with 29 C.F.R. Part 2560, including the timeframes and written notice of the decision. A written notice in electronic format, including e-mail or facsimile, may suffice for this purpose where the covered person, authorized person, or provider has agreed in advance in writing to receive such notices electronically and shall include the required elements of subsection (j) of this section;

(i) Provide a utilization review decision within twenty-four (24) hours of receipt of a request for review of a covered person's continued hospital stay and prior to the time when a previous authorization for hospital care will expire;

(j) Provide written notice of review decisions to the covered person, authorized person, and providers. An insurer or agent that denies coverage or reduces payment for a

treatment, procedure, drug that requires prior approval, or device shall include in the written notice:

1. A statement of the specific medical and scientific reasons for denial or reduction of payment or identifying that provision of the schedule of benefits or exclusions that demonstrates that coverage is not available;

2. The state of licensure, medical license number, and the title of the reviewer making the decision;

3. Except for retrospective review, a description of alternative benefits, services, or supplies covered by the health benefit plan, if any; and

4. Instructions for initiating or complying with the insurer's internal appeal procedure, as set forth in KRS 304.17A-617, stating, at a minimum, whether the appeal shall be in writing, and any specific filing procedures, including any applicable time limitations or schedules, and the position and phone number of a contact person who can provide additional information;

(k) Afford participating physicians an opportunity to review and comment on all medical and surgical and emergency room protocols, respectively, of the insurer and afford other participating providers an opportunity to review and comment on all of the insurer's protocols that are within the provider's legally authorized scope of practice; and

(l) Comply with its own policies and procedures on file with the office or, if accredited or certified by a nationally recognized accrediting entity, comply with the utilization review standards of that accrediting entity where they are comparable and do not conflict with state law.

(2) The insurer's failure to make a determination and provide written notice within the time frames set forth in this section shall be deemed to be an adverse determination by the insurer for the purpose of initiating an internal appeal as set forth in KRS 304.17A-617. This provision shall not apply where the failure to make the determination or provide the notice results from circumstances which are documented to be beyond the insurer's control.

(3) An insurer or private review agent shall submit a copy of any changes to its utilization review policies or procedures to the office. No change to policies and procedures shall be effective or used until after it has been filed with and approved by the executive director.

(4) A private review agent shall provide to the office the names of the entities for which the private review agent is performing utilization review in this state. Notice shall be provided within thirty (30) days of any change.

Section 21. KRS 304.18-036 is amended to read as follows:

(1) [~~For purposes of this section, "mental illness" means psychosis, neurosis or an emotional disorder.~~

~~(2)~~]Any offer to sell a group policy or contract of general health insurance to be issued, delivered, issued for delivery, amended or renewed in this state [~~after January 1, 1987,~~] shall include an offer of coverage for ***mental health or substance use disorder benefits in accordance with section 18 of this act*** [~~the inpatient and outpatient treatment of mental illness, at least to the same extent and degree as coverage provided by the policy or contract for the treatment of physical illnesses~~].

(2)[~~(3)~~] Nothing in this section shall be construed to prohibit an insurer from issuing or continuing to issue a health insurance policy or contract which provides benefits greater than the

minimum benefits required by this section or from issuing such policies or contracts providing benefits which are generally more favorable to the insured than those required by this section.

Section 22. KRS 304.18-032 is amended to read as follows:

(1) All group or blanket health insurance policies and certificates issued thereunder providing coverage on an expense incurred basis, regardless of whether the policies and certificates are issued for nonfamily or family coverage, shall, provide that health insurance benefits shall be payable with respect to a newly born child of the insured or certificate holder from the moment of birth.

(2) The coverage for newly born children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

(3) If payment of a specific premium or fee is required to provide coverage for a child, the policy or contract may require that notification of birth of a newly born child and payment of the required premium or fees must be furnished to the insurer within thirty-one (31) days after the date of birth in order to have the coverage continue beyond such thirty-one (31) day period.

(4) The requirements of this section shall apply to all insurance policies, and certificates issued thereunder, delivered or issued for delivery in this state on and after July 15, 1994.

(5) Discrimination based on genetic information as set forth in section 1 through 4 of this act shall be prohibited.

Section 23. KRS 304.32-153 is amended to read as follows:

(1) All individual or group service or indemnity type contracts and all certificates thereunder issued by a nonprofit corporation regardless of whether the contracts and certificates are issued

for nonfamily or family coverage shall, provide that health insurance benefits shall be payable with respect to a newly born child of the member or subscriber from the moment of birth.

(2) The coverage for newly born children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

(3) If payment of a specific premium or fee is required to provide coverage for a child, the policy or contract may require that notification of birth of a newly born child and payment of the required premium or fees must be furnished to the nonprofit service or indemnity corporation within thirty-one (31) days after the date of birth in order to have the coverage continue beyond such thirty-one (31) day period.

(4) The requirements of this section shall apply to all member or subscriber contracts, and all certificates thereunder, delivered or issued for delivery in this state on and after July 15, 1994.

(5) Discrimination based on genetic information as set forth in sections 1 through 4 of this act shall be prohibited.

Section 24. KRS 304.32-165 is amended to read as follows:

(1) [~~For purposes of this section, "mental illness" means psychosis, neurosis or an emotional disorder.~~

~~(2)~~] Any offer to sell a policy or contract of general health insurance to be issued, delivered, issued for delivery, amended or renewed by a nonprofit hospital, medical-surgical, or health service corporation [~~after January 1, 1987~~], shall include an offer of coverage for ***mental health or substance use disorder benefits in accordance with section 18 of this act*** [~~the inpatient and outpatient treatment of mental illness, at least to the same extent and degree as coverage provided by the policy or contract for the treatment of physical illnesses~~].

(2) [~~(3)~~] Nothing in this section shall be construed to prohibit an insurer from issuing or continuing to issue a health insurance policy or contract which provides benefits greater than the minimum benefits required by this section or from issuing such policies or contracts providing benefits which are generally more favorable to the insured than those required by this section.

Section 25. KRS 304.38-193 is amended to read as follows:

(1) [~~For purposes of this section, "mental illness" means psychosis, neurosis or an emotional disorder.~~

~~(2)~~]Any offer to sell a policy of general health insurance or health maintenance organization coverage issued, delivered, issued for delivery, amended or renewed by a health maintenance organization in this state [~~after January 1, 1987~~], shall include an offer of coverage for ***mental health or substance use disorder benefits in accordance with section 18 of this act*** [~~the inpatient and outpatient treatment of mental illness, at least to the same extent and degree as coverage provided by the policy or contract for the treatment of physical illnesses~~].

(2)[~~(3)~~] Nothing in this section shall be construed to prohibit a health maintenance organization from issuing or continuing to issue a health insurance policy or contract which provides benefits greater than the minimum benefits required by this section or from issuing such policies or contracts providing benefits which are generally more favorable to the insured than those required by this section.

Section 26. KRS 304.38-199 is amended to read as follows:

(1) All health maintenance organization contracts issued by health maintenance organizations, regardless of whether the contracts are for nonfamily or family coverage, shall provide that health insurance benefits shall be payable with respect to a newly-born child of the subscribed from the moment of birth.

(2) The coverage for newly-born children shall consist of coverage of injury or sickness including the necessary care and treatment of medically-diagnosed congenital defects and birth abnormalities.

(3) If payment of a specific premium or fee is required to provide coverage for a child, the policy or contract may require that the notification of birth of a newly-born child and payment of the required premium or fees must be furnished to the health maintenance organization within thirty-one (31) days after the date of birth in order to have the coverage continued beyond such thirty-one (31) days.

(4) The requirements of this section shall apply to all contracts delivered or issued for delivery in this state on and after July 15, 1994.

(5) Discrimination based on genetic information as set forth in sections 1 through 4 of this act shall be prohibited.

Section 27. The following KRS sections are hereby repealed:

304.17A-660 Definitions for KRS 304.17A-660 to 304.17A-669.

304.17A-661 Treatment of mental health conditions to be covered under same terms and conditions as treatment of physical health conditions.

304.17A-665 Executive director to report to Legislative Research Commission on impact of health insurance costs under KRS 304.17A-660 to 304.17A-669.

304.17A-669 KRS 304.17A-660 to 304.17A-669 not to be construed as mandating coverage for mental health conditions -- Exemptions from KRS 304.17A-660 to 304.17A-669.

304.18-130 Policies to cover treatment for alcoholism, exclusions.

304.18-140 Treatment of alcoholism, required provisions, minimum benefits.

304.18-150 Treatment of alcoholism, minimum benefits may be exceeded.

304.18-170 Alcoholism, definitions, requirements for treatment.

304.18-180 Executive director may adopt rules and regulations.

304.32-158 Coverage for treatment of alcoholism.

304.38-197 Coverage for treatment of alcoholism.